

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Harry Amoss

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 31 1874

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

73820

hrs.

min.

9. Birthplace

Harford Co md
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

General Work

12. Name

Harry A Amoss

13. Birthplace

Harford Co md

14. Maiden name

Rehonda Mc Lane

15. Birthplace

Harford Co md

16. Informant

Virginia Pearson

Address

Beltsville Pa

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 22 1947
(month) (day) (year)

Cemetery or crematory

St Pauls

Location

Beltsville md

18. Funeral director

W Howard Webb

Address

Ham Dale Pa

19.

12/20

19.

47 P Fourwood

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 16 1947 to Dec 18 1947and that I last saw him alive on Dec 17 1947

Immediate cause of death

CORONARY THROMBOSIS

DURATION

36 hr.

Due to

Due to

Other conditions

ch. myocardial Arterian ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

Address Forest Hill Md Date signed 12/18/47

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DEC 24 1947

BUREAU 9 A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11285

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County... HarfordCity or town... Dyersville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... HarfordCity or town... Dyersville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 31 19 47, at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1 19 47, to Dec 31, 19 47and that I last saw her alive on Dec 29, 19 47Immediate cause of death... Arterio sclerosis

DURATION

1 yr.

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof... Jan 3 19 48
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1948

Thomas R. Brown
Registrar

23. SIGNATURE

Address

M. D. or other

Date signed 1-1-48

MARGIN RESERVED FOR BINDING

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9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11288

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Fine de grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 9 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 665 Bel Air Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mr Ambrose Armstrong

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Beulah E. Bowman

7. Birth date of deceased (mo., day, yr.)

January 7, 1869

6. (c) If alive, give age years

8. AGE:

7810Days

If less than one day

hrs.min.

9. Birthplace

Lexington, Harford Co., Md.
(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

MOTHER FATHER

12. Name

J. Sidney Armstrong

13. Birthplace

Harford Co., Md.

14. Maiden name

Catherine Gilbert

15. Birthplace

Harford Co., Md.

16. Informant

Mr. G. Robert Armstrong

Address

665 E. Bel Air Ave. Aberdeen

17. Burial

Burial Date thereof Dec. 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Smiths Chapel

Location

Churchville, Md.

18. Funeral director

Henry Tarrington & Sons

Address

Aberdeen, Md.

19. Dec. 2

19. 47 G. L. Lewis Jr. & S.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 18, 1947 1 05 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 / 47 19, to Dec 18 / 47 19, and that I last saw him alive on November 30, 1947

Immediate cause of death

DURATION

Pulmonary embolismDue to Chronic myocarditisDue to ArteriosclerosisOther conditions Embolism of uterine artery

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

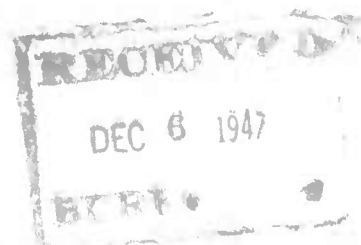
Injured at work?

23. SIGNATURE

John F. Noyes

M. D. or other

Address Harford Harford Co. Date signed 12/1/47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Rural Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35-year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Henry M Bowler

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife Nattie L Epperly Bowler7. Birth date of
deceased (mo., day, yr.)Dec 26-1874

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

73

hrs.

min.

9. Birthplace

Va

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

James Bowler

13. Birthplace

Va

14. Maiden name

Sarah E Martin

15. Birthplace

Va

16. Informant

Mrs H M Bowler

Address

Bel Air, Md

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Dec 21/47
(month) (day) (year)

Cemetery or crematory

MT Zion

Location

Fountain Green

18. Funeral director

Jos. J. Foster

Address

Bel Air, Md

19.

12/20
(Date rec'd by registrar)

19.

47 P. Woodward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1947 at 8:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 4 1947 to Dec 19 1947
and that I last saw him alive on Dec 19 1947

Immediate cause of death

Pulmonary Edema
Terminating

DURATION

2 hrs

Due to

chr myocardial Disease 18+

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Leonard P. Hudson

M. D. or other

Address Forest Hill Md Date signed 12/20/47

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DEC 24 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11290

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford
 City or town Madonna
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 1/2 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Harford
 City or town Madonna
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Alberta Branscome

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Frank Branscome

7. Birth date of deceased (mo., day, yr.)

Sept 14 1854

6. (c) If alive, give age _____ years

8. AGE:

9330

Years Months Days

hrs.

min.

9. Birthplace

Laurel Fork, VA
(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

MOTHER FATHER

12. Name

John Jackson

13. Birthplace

VA.

14. Maiden name

Nancy Bowman

15. Birthplace

VA.

16. Informant

Marlys Dusenberry

Address

Rocks R.D. Md.

17.

Buried
(Burial, cremation, or removal, Which?)

Date thereof

Dec 17 - 47
(month) (day) (year)

Cemetery or crematory

Hillville

Location

Hillville Carroll Co VA.

18. Funeral director

Martin G. Kuntz

Address

Janettsville Md.

19.

Dec 16
(Date rec'd by registrar)

19.

1947 Thomas R. Brown

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1947 at 10²² A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 13 1947 to Dec 14 1947and that I last saw her alive on Dec 13 1947

Immediate cause of death

LOBAR PNEUMONIATerminating a
Cerebral Hemorrhage

DURATION

2 days5 days

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

Address

Forest Hill MdDate signed 12/15/47

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DEC 17 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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11291

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
City or town Shore de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Shore de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 344 Wilson Street
(If rural, give LOCATION)
2. (a) If veteran, name war World War II

3. (a) FULL NAME

Anthony BRASWELL

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bernice Braswell

7. Birth date of deceased (mo., day, yr.) 3/13/23 6. (c) If alive, give age _____ years

8. AGE: Years 24 Months 7 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace White Springs, Fla.
(Town, county, and state)

10. Usual occupation Hospital Ward Attendant

11. Industry or business

12. Name no record

13. Birthplace

14. Maiden name no record

15. Birthplace

16. Informant Personal kept

Address Perry Point Hospital, Maryland

17. Funeral Burial Date thereof 12-12-47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory To Harry J. Reid

Location Jasper, Florida

18. Funeral director Elmer E. Bullock

Address 556 Lewis St. Shore de Grace Md

19. Dec. 5 19 47 G. E. Lewis m. D.
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 19 47 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 47 to Same 19 47 and that I last saw him alive on Same 19 47

Immediate cause of death Intracranial Hemorrhage

Due to Basal fracture of Skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/1/47

Where did injury occur? near Shore de Grace Harford Md
(City or town) (County) (State)

Means of Injury Auto accident Injured at work? No

Signature J. Ramsey m. D.

Address Aberdeen, Md. Date signed 12/1/47

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9-45-15

VS A15

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH.

Reg. Dist. No. 180

1. PLACE OF DEATH:

County..... Harford
City or town..... Edgewood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Station Hospital, Army Chemical Ctr., Md.

How long in hospital or institution?

4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Texas County.....

City or town..... Marion
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war..... World War II

3. (a) FULL NAME

Brawner, Wilburn Wille

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife..... Unknown		
7. Birth date of deceased (mo., day, yr.) April 5, 1915		
8. AGE: Years 32	Months 7	Days 29
If less than one day hrs. min.		

9. Birthplace..... Kingsbury, Texas
(Town, county, and state)

10. Usual occupation..... U. S. Army

11. Industry or business

FATHER 12. Name..... William C. Brawner
13. Birthplace..... United States

MOTHER 14. Maiden name.....
15. Birthplace..... United States

16. Informant..... Form 66
Address..... United States Army

17. Transportation Dec 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Gostz Funeral Home
Location..... Seguin Texas

18. Funeral director..... Howard K. McComas & Son
Address..... Abingdon Md.

19. Dec 5, 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4 December 1947 at 2:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10:30 pm 3 December 1947 to 4 December 1947
and that I last saw him alive on 4 December 1947

Immediate cause of death..... Subarachnoid hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... Hemorrhage, acute, cerebellar, severe

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Louis S. Biancato, Capt., MC
M. D. or other

Address..... Station Hosp., ACC., Md. Date signed..... 4 Dec 47

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DEC 8 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11293

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH

County HarfordCity or town Bel Air Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Lee Bull

3. (b) Social Security Number

4. Sex M. 5. Color or race Ok. 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Alice M. Bull7. Birth date of deceased (mo., day, yr.) July 26 - 1873

6. (c) If alive, give age _____ years

8. AGE: Years 77 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Md
(Town, county, and state)10. Usual occupation Tailor

11. Industry or business

12. Name Harry Bulls13. Birthplace Md14. Maiden name Elizabeth Wagner15. Birthplace Md16. Informant Alice M. BullAddress Bel Air Md.17. Burial Date thereof Dec 19 1947
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory Rock SpringsLocation Forest Hill Md.18. Funeral director Clarence E. ArthurAddress Fork Md19. 12/17 19 47 Pfowood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 19 47 at 10A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 38 to Dec 16 19 47 and that I last saw h. 1 M alive on Dec 10 19 47

Immediate cause of death

Arteriosclerotic cardiovascular disease

DURATION

10 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Gerald C Palmer MD

M. D. or other

Address Bel Air Md Date signed 12/16/47

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DEC 19 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1066

11294

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
City or town Abersden
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County Harford
City or town Abersden Housing Project
(if outside city or town limits, write RURAL and give nearest town)
Street No. 14 Defense Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

INA MABLE BURNING

3.(b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

8.(b) Name of husband or wife LAWSON COURTNEY BURNING 8.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) OCT. 18, 1882

8. AGE: Years 65 Months 2 Days 10 If less than one day hrs. min.

9. Birthplace Harford Co Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown Smith

13. Birthplace

MOTHER 14. Maiden name unknown

15. Birthplace

16. Informant Charles Burkings

Address Abersden Ind.

17. Burial Date thereof Dec 31, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Southern Cemetery

Location Abersden Harford Co Ind.

18. Funeral director H. S. Bailey

Address Berlin Ind.

19. Dec-29-47 Nellie H. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1947, at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to 1944

and that I last saw him alive on 1944

Immediate cause of death Massive Hemorrhage of lung

Due to known to have had bronchiectasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till to the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Astham MD M. D. or other

Address Abersden Ind. Date signed 12/29/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11295

Reg. Dist. No. 183

1. PLACE OF DEATH:

County HarfordCity or town Black Horse
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 75 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Black Horse
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Anna Maria Gibson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Aug 3 1896

8. AGE:

Years

Months

Days

If less than one day

5147

hrs. min.

9. Birthplace Janetville Harford Co. Md.
(Town, county, and state)10. Usual occupation housekeeper

11. Industry or business

FATHER
MOTHER

12. Name

Nebbin Gibson

13. Birthplace

Mt. Nebo Lancaster Co. Pa.

14. Maiden name

Emma Chambers

15. Birthplace

Shawville Harford Co. Md.

16. Informant

Allen Gibson

Address

White Hall Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Dec 13 47
(month) (day) (year)

Cemetery or crematory

Bethel

Location

Madonna Harford Co. Md.

18. Funeral director

Address

Janetville Md.

19. Dec. 13

(Date rec'd by registrar)

19 47

Thomas R. Brown

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 19 47 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 819 47 to Dec 1019 47and that I last saw him alive on Dec 10 19 47

Immediate cause of death

Cardiac failure

DURATION

Due to

Etiology undetermined

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. James Thomson, Jr.

M. D. or other

Address

Janetville, Md. Date signed Dec 13 47

RECEIVED
DEC 17 1947
ST. LOUIS, MO.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Clara Virginia Grey

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Charles Alfred Grey
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1858

8. AGE: Years 89 Months 0 Days 23 If less than one day hrs. min.

9. Birthplace Thomas Run Harford Co Md
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name John F Bull

13. Birthplace Thomas Run

14. Maiden name Cornelia Hollingsworth

15. Birthplace Balto city

16. Informant Elizabeth R Bull

Address Forest Hill Md

Burial Date thereof Dec 17 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Centre

Location Forest Hill Harford Co Md

18. Funeral director Walter E. Kutz

Address Janetville Md

19. Dec 16 1947 Thomas R. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1947, at 7³⁰ A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 1947, to Dec 15 1947, and that I last saw her alive on Dec 11 1947

Immediate cause of death CORONARY OCCLUSION

DURATION SUDDEN DEATH

Due to.

Due to.

Other conditions Chr MYOCARDIAL DISEASE
decompensated.
(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Winard R Hudson
M. D. or other

Address Forest Hill Md Date signed 12/15/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. No correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

DEC 17 1947

60334078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11297

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford
 City or town Federal Hill (Rocks R.D.)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Nelson Holland

3. (b) Social Security Number

4. Sex

Male

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 15 1892

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

557

hrs.

min.

9. Birthplace

Madonna, Harford co md
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

Farm

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.47

Thomas P. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Harford
 City or town Federal Hill (Rocks R.D.)
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1947 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 20, 1944 to Dec. 22, 1947and that I last saw him alive on Dec. 14 1947Immediate cause of death Pulmonary edema

DURATION

3 wks.Due to Chronic congestive failure 2 yrs.Due to Hyper tensive cardiovascular disease 5 yrs.Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

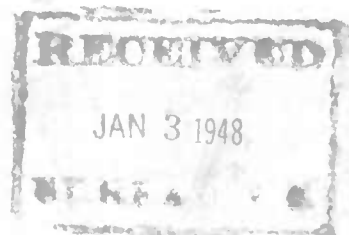
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 12-22-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11298

Reg. Dist. No. 185

1. PLACE OF DEATH:

County... Harford
 City or town... Harford, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 hrs.
 Hospital, institution, or street address where death occurred:
Home of Dr. Wm. Daniel
 How long in hospital or institution? 48 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Harford
 City or town... Harford, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Water
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3.(a) FULL NAME

Joseph Hughes Jr.

3.(b) Social Security Number

4. Sex... Male 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Widowed
 6.(b) Name of husband or wife... dec.
 7. Birth date of deceased (mo., day, yr.)... April 11-1868
 8. AGE: Years... 82 Months... 8 Days... 9 If less than one day... hrs. min.

9. Birthplace... Harford, Md. (Town, county, and state)10. Usual occupation... Fisherman

11. Industry or business...

12. Name... Gene Hughes13. Birthplace... Chesapeake City Md.14. Maiden name... Mary?15. Birthplace... Chesapeake City16. Informant... Mrs. Joseph Hughes Jr.Address... Harford, Md.17. Burial Date thereof 12/29/47 (month) (day) (year)Cemetery or crematory... Angel HillLocation... Harford, Md.18. Funeral director... Funerary (Rm)Address... Harford, Md.19. Dec. 22 19 47 G. L. Lewis M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... 12-20 19 47 at 6:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-18 19 47, to 12-20 19 47and that I last saw him alive on 12-20 19 47Immediate cause of death... Branchial DURATION 48 hrs.Due to... Sensitivity - ExposureDue to... MalnutritionOther conditions... Myocarditis chronic

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. D. M. D. or otherAddress... Port Deposit Date signed... 12-20-47

RECEIVED
DEC 26 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11299

186-

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Cherden Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 212 - Gt 3 Baldwin Manor
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Baby Boy Killion, (Neil) Jr.

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec. 4th / 47 at 4⁵⁰ PM

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1 hrs. 50 min.

9. Birthplace

Harford Md
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Neil B. Killion

13. Birthplace

Chesland La

14. Maiden name

Betty Mae Hill

15. Birthplace

Carson La

16. Informant

Mrs. Neil B. Killion

Address

212 - Gt 3 Baldwin Manor Cherden Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Dec. 5th 1947
(month) (day) (year)

Cemetery or crematory

Grave

Location

Cherden Md

18. Funeral director

Mrs. Mary Taylor House

Address

Cherden Md

19.

Dec. 5th 1947
(Date rec'd by registrar)

19

47G. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 4 / 47

19

at

5⁵⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 4th 1947

19

to

same

19

and that I last saw him alive on same 19

Immediate cause of death

Respiratory failure of central origin

DURATION

Due to

Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera M.D.

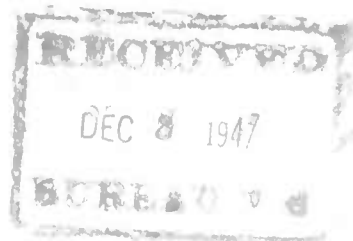
M. D. or other

Address

Hospital - Harford Md

Date signed

12/4/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

11300

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 420 Freedom St
 (If rural, give LOCATION)

2.(a) If veteran, name war -

3. (a) FULL NAME

Mrs Earlene Leslie

3. (b) Social Security Number

-4. Sex F. 5. Color or race C. 6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Edward Leslie7. Birth date of deceased (mo., day, yr.) 4-13-18906. (c) If alive, give age 54 years8. AGE: Years 55 Months Days It less than one day

hrs. min.

9. Birthplace Penn.

(Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

12. Name Link Scott13. Birthplace Penn.14. Maiden name Link15. Birthplace Penn.16. Informant Edward LeslieAddress Harre de Grace, Md.17. Burial Date thereof Dec. 5, 1947

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. JamesLocation Harre de Grace, Md.18. Funeral director T. Madison MitchellAddress Harre de Grace, Md.19. Dec. 4 19. 47 G. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 1947 at 4¹⁵ P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1947 to Dec 1st 1947and that I last saw him alive on Dec. 1st 1947

Immediate cause of death

Chronic glomerulonephritis+ congestive heart failureDue to Hypertensive cardiovasculardisease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Noguera M.D.Address Hospital - Harre de Grace Date signed 12/1/47

RECEIVED

DEC 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11301

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:

County.....*Harford*
 City or town.....*Joppa md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*61 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....*md* County.....*Harford*
 City or town.....*Joppa Rural md*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*Kelleville*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Edna Catherine Mc Courtney Lewis

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*white* 6.(a) Single, married, widowed, or divorced.....*married*

6.(b) Name of husband or wife.....*Joseph H Lewis*

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....*Aug. 22 - 1886*

8. AGE: Years.....*61* Months.....*4* Days.....*15* If less than one day..... hrs. min.

9. Birthplace.....*Harford County md*
 (Town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business.....

12. Name.....*Oliver McCourtney*

13. Birthplace.....*Lancaster Co. Pa*

14. Maiden name.....*Mary B. Singer*

15. Birthplace.....*Harford Co. md*

16. Informant.....*Mary Lewis Silling*

Address.....*Joppa md*

17. (Burial, cremation, or removal, Which?).....*Burial* Date thereof.....*Dec. 9 1947*
 (month) (day) (year)

Cemetery or crematory.....*Jerusalem Christian Cemetery*

Location.....*Joppa md*

18. Funeral director.....*W. H. Archer*

Address.....*Benson, md*

19. *12/8* 19 *47* *Priscilla Fourwood*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*December 7* 19 *47* at *9A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 1 19 *47* to *Dec 7* 19 *47*

and that I last saw her alive on *Nov 1* 19 *47*

Immediate cause of death.....

Atherosclerotic Cardiovascular Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

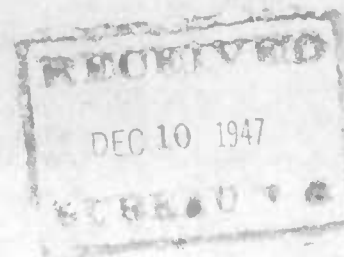
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Gerald E Palmer MD*

Address.....*Bel Air md* Date signed.....*12/8/47*

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1068

11302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town HARFORD RUTLEDGE MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORDCity or town WEST BRANCH RD.

(If outside city or town limits, write RURAL and give nearest town)

Street No. RUTLEDGE MD.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

RUTH A MILLIDGE

3.(b) Social Security Number

4. Sex

FEMALE

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

EDWARD T MILLIDGE

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

3-24-1898

8. AGE:

Years

49

Months

8

Days

8

If less than one day

..... hrs. min.

9. Birthplace

MASS.

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

FATHER

12. Name

THOMAS WALTON

13. Birthplace

NORWAY

MOTHER

14. Maiden name

MARY JANE GRAHAM

15. Birthplace

IRELAND

16. Informant

EDWARD T. MILLIDGE

Address

WEST BRANCH RD. RUTLEDGE MD.17. BURIAL

(Burial, cremation, or removal-Which?)

Date thereof

12-3-47

(month) (day) (year)

Cemetery or crematory

GREEN LAWN CEMETERY

Location

LYNN - MASS.

18. Funeral director

John O. Mitchell & Co. Inc.

Address

1900 Easton Place Calo. Md.19. 12-3-47

(Date rec'd by registrar)

19. 4719. 47ADULT

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 2, 19 47, at 1:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10:30 AM DEC. 2 19 47 to 1:40 P.M. DEC. 2 19 47.and that I last saw h.c. alive on DEC. 2nd 19 47.

Immediate cause of death

Pulmonary Edema.

DURATION

48 hours

Due to

Chillsy Undetermined

Due to

Other conditions

Chronic Bronchitis.(?) years.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

James Shannon Jr.

M. D. or other

Address Jarrettsville Md. Date signed Dec 2, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11303 185

1. PLACE OF DEATH:

County Hagerford
 City or town Hagerford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 83 yrs 6 mos. 29 days
 Hospital, institution, or street address where death occurred:
Hagerford Memorial Hospital
 How long in hospital or institution? 6 mos - 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Hagerford
 City or town Hagerford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 827 N. Union Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Elizabeth M. Parker

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Joseph C. Parker (dec.)

7. Birth date of deceased (mo., day, yr.)

5-26-1864

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

83629

hrs.

min.

9. Birthplace

Hagerford

(Town, county, and state)

10. Usual occupation

Home Wife

11. Industry or business

MOTHER

12. Name

Stephen M. Mattingly

13. Birthplace

Hagerford

14. Maiden name

Elizabeth Mattingly

15. Birthplace

Hagerford

16. Informant

Dorothy K. Parker

Address

16 Rogers St. Annapolis, Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

12/28/47

(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Hagerford

18. Funeral director

Remington & Son

Address

Hagerford

19.

(Date rec'd by registrar)

Dec. 271947G. L. Lewis Jr.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 25, 1947 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 17-47 1947 to Dec 25 1947and that I last saw him alive on Dec 23-47 1947

Immediate cause of death

Arteriosclerosis

Due to

Due to

Other conditions

Cervical arthritisSeizure

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera

M. D. or other

Address Hagerford - Hagerford Date signed 12-25-47

RECEIVED

DEC 30 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11304

180

1. PLACE OF DEATH:

County..... HARFORDCity or town..... CLAR STEPNY
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD. County..... HARFORDCity or town..... JOPPA - RURAL
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

WALTER HOWARD PIERCE

3. (b) Social Security Number

Unrecorded

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Tena L. Pierce

7. Birth date of

deceased (mo., day, yr.)

Jan. 15, 1893

6.(c) If alive, give age..... Years

8. AGE:

Years

Months

Days

If less than one day

541021

hrs.

min.

9. Birthplace.....

Brasshar Balto. Co. Md
(Town, county, and state)

10. Usual occupation.....

Section Foreman

11. Industry or business.....

B & O R.R. Co

FATHER

12. Name.....

Geo. F. Pierce

13. Birthplace.....

Balto Co. Md

MOTHER

14. Maiden name.....

Elizabeth Christy

15. Birthplace.....

Harford Co. Md

16. Informant.....

Mr. Tena L. Pierce

Address.....

Joppa Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

Dec. 10, 1947
(month) (day) (year)

Cemetery or crematory.....

Trinity Lutheran

Location.....

Joppa Md

18. Funeral director.....

Howard H. McCormack

Address.....

Aberdeen Maryland

19. (Date rec'd by registrar)

Dec 6 1947

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... DEC. 6 1947 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Coronary occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. Lawrence M.D.Deputy medical Examiner

Address.....

Aberdeen, MdDate signed..... 2/6/47

RECEIVED

DEC 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 11305
 Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) if veteran, name war.....

3. (a) FULL NAME

Joseph Carson Root

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....
 11. Industry or business.....

12. Name.....
 13. Birthplace.....

14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....

17. Burial..... Date thereof.....
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....
 Location.....

18. Funeral director.....
 Address.....

19. 12/11/47.....
 (Date read by registrar)

20. 47.....
 Registrar

21. 12/11/47.....
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw h..... alive on.....
 Immediate cause of death.....
 DURATION.....

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....
 Address..... Date signed.....

24. SIGNATURE.....
 Address..... Date signed.....

25. SIGNATURE.....
 Address..... Date signed.....

26. SIGNATURE.....
 Address..... Date signed.....

27. SIGNATURE.....
 Address..... Date signed.....

28. SIGNATURE.....
 Address..... Date signed.....

29. SIGNATURE.....
 Address..... Date signed.....

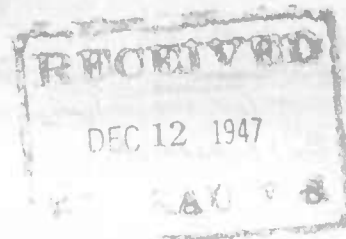
30. SIGNATURE.....
 Address..... Date signed.....

31. SIGNATURE.....
 Address..... Date signed.....

32. SIGNATURE.....
 Address..... Date signed.....

33. SIGNATURE.....
 Address..... Date signed.....

34. SIGNATURE.....
 Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11739 181

1. PLACE OF DEATH:

County HarfordCity or town near Aberdeen
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. Beth Chapel Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Warren Winfield Presbury

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lolence Christy

7. Birth date of

deceased (mo., day, yr.)

June 5, 18986. (c) If alive, give age 54 years

8. AGE:

Years

Months

Days

If less than one day

496

hrs.

min.

9. Birthplace

Aberdeen Harford Co., Md.
(Town, county, and state)

10. Usual occupation

Day laborer

11. Industry or business

U. S. Government, A.P.L.

MOTHER FATHER

12. Name

Nelson Presbury

13. Birthplace

Aberdeen, Md.

14. Maiden name

Liza Brooks

15. Birthplace

16. Informant

Mrs. Lolence Presbury

Address

Aberdeen, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 31, 1947

(month) (day) (year)

Cemetery or crematory

Mt Calvary

Location

near Aberdeen

18. Funeral director

Henry Tarring & Sons

Address

Aberdeen, Md.

19.

(Date rec'd by registrar)

Dec. 31, 1947Nellie H. Eley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1947 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 24, 1947 to Dec. 28, 1947and that I last saw him alive on Dec. 27, 1947

Immediate cause of death

Coronary decomposition

DURATION

7 mos.

Due to

initial insufficiency

Due to

arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

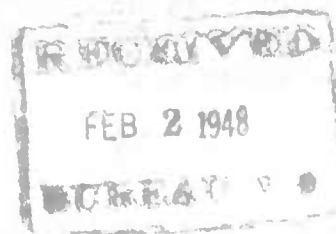
23. SIGNATURE

Nelson P. Thompson

M. D. or other

Address

Aberdeen, Md.Date signed Dec. 30/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4627 11306 85-

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)Street No. 709 Hopkins Alley
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rose Ramsey

3. (b) Social Security Number

4. Sex Female5. Color or race Negro6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife dec.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 - 19038. AGE: Years 44 Months 6 Days 14 If less than one day hrs. min.9. Birthplace Alabama
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address 709 Hopkins Alley17. Burial Date thereof 12/11/47
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory St. JamesLocation Home de Peace18. Funeral director Remington & SonAddress Harford, Md.19. Dec 10 19 47 A. L. Lewis, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 19 47, at 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 19 47, to Dec 8 19 47, and that I last saw him alive on Dec 8 19 47.

Immediate cause of death

Carcinoma of sigmoid
Due to Cachexia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Soling, M.D.Address Harford, Md. Date signed Dec 12/47

RECEIVED

DEC 13 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11307

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HartfordCity or town Emmorton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HartfordCity or town Emmorton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George T. Sherman

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M6.(b) Name of husband or wife Mary K. Gilling Sherman7. Birth date of deceased (mo., day, yr.) Feb 17-1868 6.(c) If alive, give age _____ years8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Hanover Pa
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

12. Name George T. Sherman13. Birthplace Pa14. Maiden name Elizabeth Heck15. Birthplace Pa16. Informant Mrs Mary K. ShermanAddress Bel Air, Md RD 2 Box 6817. Burial Date thereof Dec 8/47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt ZionLocation Fountain Green18. Funeral director Joseph J. FortAddress Bel Air Md19. 12/8 19 47 Priscilla Farwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 19 47 at 7:35 A.M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 47 to Dec 5 19 47 and that I last saw him alive on Dec 1 19 47Immediate cause of death Carcinoma Stomach DURATION 18 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson M. D. or other _____Address Forest Hill Md Date signed 12/5/47

RECEIVED

DEC 10 1947

BUREAU

RECEIVED

DEC 10 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11308

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harre de Grace Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 200 So. Union Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Bartol Silver

3. (b) Social Security Number

—

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Francina C. Haskins

7. Birth date of deceased (mo., day, yr.)

Nov. 17, 1867

6. (c) If alive, give age

75 years

8. AGE:

8014

If less than one day

hrs.

min.

9. Birthplace

Acil Co. Md.
(Town, county, and state)

10. Usual occupation

Canna Insurance Banking

11. Industry or business

George B. Silver

12. Name

Md.

13. Birthplace

Charlotte Catherine Hughes

14. Maiden name

Md.

15. Birthplace

16. Informant

Mrs. Fannie N. Silver

Address

Harre de Grace, Md.

17.

Burial
(Burial, cremation, or removal, which?)

Date thereof

Dec. 23, 1947
(month) (day) (year)

Cemetery or crematory

Rock Run

Location

Harford Co. Md.

18. Funeral director

R. Madison Mitchell

Address

Harre de Grace Md.

19.

Dec. 23 19 47
(Date rec'd by registrar)G. L. Lewis M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 2119 47at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 20 19 47

and that I last saw him alive on

Dec. 21 19 47

Immediate cause of death

Pulmonary Embolism

DURATION

Due to

Broncho Pneumonia

Due to

Other conditions

Asperteric arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. J. Simon M.D.

M. D. or other

Address

Harre de GraceDate signed 12-23-47



11310

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195d

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HARFORD
 City or town HAVRE DE GRACE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Dead on arrival
 Hospital, institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County ABERDEEN
 City or town ABERDEEN
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 23 FENWAY
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

GLADYS

STALLWORTH

3. (b) Social Security Number

✓

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE COLORADO SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 10-21-47

8. AGE: Years Months Days If less than one day
2 10 hrs. min.9. Birthplace HARFORD-HAVRE DE GRACE MD
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name HOWARD STALLWORTH

13. Birthplace GULFPORT MISS.

14. Maiden name KATTIE M. BROWN

15. Birthplace ASHVILLE N.C.

16. Informant HOWARD STALLWORTH

Address 23 FENWAY ABERDEEN MD.

17. BURIAL Date thereof JAN 2 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory UNION METHODIST

Location ABERDEEN MD.

18. Funeral director Oliver E. Bullock

Address 556 Lewis St. Harford, Md.

19. Jan. 3 48 A. D. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 31 1947 at 8:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

ASPHIXIATION - ACCIDENTAL

Due to ASPIRATED VOMITUS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of 12/31/47

Where did injury occur? ABERDEEN HARFORD MD.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HOME

Means of injury aspiration of vomitus Injured at work? -

23. SIGNATURE

Address

Date signed 12/31/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11311

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital
4 hours

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 131 N. Washington St
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Harold

3. (b) Social Security Number

Thompson

4. Sex

M

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

IDA F. Thompson

7. Birth date of deceased (mo., day, yr.)

11-24-18786.(c) If alive, give age 68 years

8. AGE:

Years

Months

Days

If less than one day

6916

hrs.

min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

C & P. Telephone Co

FATHER

12. Name

Charles F. Thompson

13. Birthplace

Md.

MOTHER

14. Maiden name

Emily E. Baker

15. Birthplace

Md.

16. Informant

Mrs. Ida F. ThompsonAddress 131 N. Washington St. City

17.

BurialDate thereof Jan. 2 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Angel Hill Cem.

Location

Harre de Grace, Md.

18. Funeral director

R. Madison MitchellAddress Harre de Grace, Md.

Jan. 2

19. 48

G. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 20

19

47 at 5²⁰ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 30/47

19

to

same

19

and that I last saw h. alive on same

19

Immediate cause of death

DURATION

Coronary heart disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

John F. Noguera M.D.

M. D. or other

Address

Hospital - Harre de GraceDate signed 12/30/47

RECEIVED

JAN 5 1948

BUREAU V C

RECEIVED

DEC 16 1947

BUREAU P. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 11313
 1628
 Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Benjamin Franklin Webster

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 19, 1862
 6. (c) If alive, give age _____ years

8. AGE:

85

Years

5

Months

21

Days

If less than one day

hrs.

min.

9. Birthplace

Sandy Hook, Harford Co. Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 12/18

(Date rec'd by registrar)

19. 47

Priscilla Toward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11, 1947 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 to Dec 11, 1947
 and that I last saw him alive on Dec 11, 1947

Immediate cause of death

Myocardial failure

DURATION

Due to

Age

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

M. D. or other
Bellevue
Date signed 12/13/47

RECEIVED

DEC 17 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11314

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Bainbridge Naval Base
(If outside city or town limits, write RURAL and give nearest town)Street No. Blg 911 Apt. 9
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Baby Ronald Lee Wilmoth

3.(b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Newborn infant.

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

December 16 / 47 at 11:27 PM

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9

hrs.

min.

9. Birthplace

Harford
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

Marlow D. Wilmoth

13. Birthplace

West Va.

14. Maiden name

Margaret G. Shatz

15. Birthplace

Pa.

16. Informant

Marlow D. Wilmoth

Address

Bainbridge Naval Base Md

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

Dec. 20, 1947
(month) (day) (year)

Cemetery or crematory

Chamberburg

Location

Chamberburg Pa.

18. Funeral director

Pennington & Son

Address

Harford Md.19. Dec. 18

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MEDICAL CERTIFICATION

20. DATE OF DEATH

December 17th 19 47 at 8²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 17/47 19 to name 19and that I last saw him alive on Dec 17/47 19

Immediate cause of death

Asphyxia due to central
respiratory failure

Due to

Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

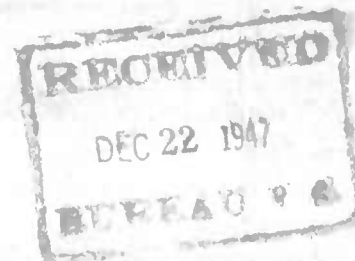
23. SIGNATURE

John F. Noguera MD

M. D. or other

Address Hospital - Harford signed 12/17/47

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11315

Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....
 City or town..... *Hartford*
Bel Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *30 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... *Md* County..... *Hartford*
 City or town..... *Bel Air, Md*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *30 Broadway*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

R Blanche Wilson

3. (b) Social Security Number

4. Sex..... *F*
 5. Color or race..... *W*
 6.(a) Single, married, widowed, or divorced..... *S*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... *Feb 13 - 1880*
 8. AGE: Years..... *67* Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... *Bel Air, Md*
 (Town, county, and state)
 10. Usual occupation..... *Retired*
 11. Industry or business.....

12. Name..... *Harry Wilson*
 13. Birthplace..... *Md*

14. Maiden name..... *Priscilla Blake*
 15. Birthplace..... *Md*

16. Informant..... *Miss Anna Wilson*
 Address..... *Bel Air, Md*

17. *Burial* (Burial, cremation, or removal. Which?) Date thereof..... *Dec 17/47*
 (month) (day) (year)

Cemetery or crematory..... *Trinity*
 Location..... *Churchville, Md*

18. Funeral director..... *J. J. Fisher*
 Address..... *Bel Air, Md*

19. *12/16* (Date rec'd by registrar) *47* Registrar *P. Howard*

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Dec 15* 19*47* at *7:50 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1939* to *Dec 15 - 47*
 and that I last saw him alive on *Aug* 19*47*

Immediate cause of death..... *Acute Myocarditis*
 DURATION.....

Due to..... *Myocarditis*
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *M. J. Fisher*
 M. D. or other

Address..... *Bel Air, Md* Date signed..... *12/16/47*

RECEIVED
DEC 19 1947
SERIAL 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11316 185

1. PLACE OF DEATH:

County Harford
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Harford
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Carsino Run P.D. #2
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Winterling

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife George Winterling 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb 13, 1857
 8. AGE: Years 90 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md
 (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business
 12. Name William Vogler
 13. Birthplace Germany
 14. Maiden name Catherine Bechtold
 15. Birthplace Germany

16. Informant Catharine the Bride-daughter
 Address Abandon RD #2 Md

17. Burial Date thereof 12-30-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Schwartz
 Location Baltimore Md

18. Funeral director Ullrich Funeral Home
 Address 2018 Orleans St

19. 12/27/47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1947 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 to Dec 1947 and that I last saw him alive on Dec 26 1947

Immediate cause of death acute pulmonary edema

Due to arterio-sclerotic C.V. Disease 15 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. Ralph Hardy MD
Churchville Md M.D. or other
 Address Date signed Dec 28

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **11317**
182

1. PLACE OF DEATH:

County Harford
City or town Foggs m
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Dorchester

City or town near Christ Rock
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs Lucy Young

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Daniel Young

6. (c) If alive, give age 89 years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Christ Rock, Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business _____

12. Name Ben Cornish

13. Birthplace Dor Co

14. Maiden name Caroline Hill

15. Birthplace Dor Co, Md.

16. Informant Daniel Young

Address Foggs m

17. (Burial, cremation, or removal, Which?) Burial Date thereof Jan 2, 1948
(month) (day) (year)

Cemetery or crematory Cemetery, Dor Co

Location Christ Rock, Md.

18. Funeral director Sewid H Boyneum

Address Cornbridge, Md.

19. 12/31 19 47 W. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 19 47 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 19 47 to Dec 30 19 47

and that I last saw him alive on Dec 30 19 47

Immediate cause of death Cancer of cervix

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jed O Hodous MD

Address Edgewood Md Date signed 12-30-47

MARGIN RESERVED FOR BINDING

I

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 3 1948
ETHIOPIA